STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING _____ B. WING _____	R-C 03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the PSR completed on 2/26/15 to the Investigation of Complaint IN00160464 completed on 12/18/14.

This visit was in conjunction with the PSR to the PSR completed on 2/26/15 to the Recertification and State Licensure Survey completed on 12/5/14.

This visit was in conjunction with the PSR to the PSR completed on 2/26/15 to the Investigation of Complaint IN00162446 completed on 1/13/15.

This visit was in conjunction with the PSR to the Investigation of Complaints IN00163785, IN00164923, and IN00164979 completed on 2/26/15.

Complaint IN00160464-Corrected.

Survey Dates: March 12 & 13, 2015

Facility number: 000076
Provider number: 155156
AIM number: 100271060

Survey Team:
Heather Tuttle, RN-TC
Janelyn Kulik, RN
3/12/15

Census bed type:
SNF: 33
SNF/NF: 105
Total: 138

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING _____ B. WING _____	R-C 03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT MICHIGAN CITY	**1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Census payor type: Medicare: 34 Medicaid: 90 Other: 14 Total: 138 Arbors at Michigan City was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the PSR Investigation of Complaint IN00160464. Quality review completed on March 18, 2015, by Janelyn Kulik, RN.	{F 000}		